

VSH Futures Advisory Committee
May 7, 2007 2:00 – 4:30 PM
Skylight Conference Room, Waterbury

Minutes

Next meeting: June 4, 2007 2:00 p.m. to 4:30 p.m.
Hazens Notch, Cyprian Learning Center (NEW LOCATION!)
State Office Complex, Waterbury

Present

Deputy Commissioner for Mental Health Michael Hartman

Advisory Committee Members: Kitty Gallagher, Adult State MH Program Standing Committee; Ron Smith, DOC; Jeff Rothenberg, CMC; Jack McCullough, MHLP; Sally Parrish, advocate; Conor Casey, VSEA; Paul Dupre, WCMH, Vermont Council; Ed Paquin, VP&A; Larry Lewack, NAMI-VT; Michael Sabourin, advocate; Anne Jerman, VSH; JoEllen Swaine, VSH; Peter Albert, Retreat Healthcare; Ken Libertoff, VAMH; Xenia Williams, advocate; Sandy Steingard, HCHS; Meg O'Donnell, FAHC; Anne Jerman, VSH; Larry Thomson, VSH

Guests/Public:

Robert Simpson, Retreat Healthcare; Jim Walsh, Springfield Hospital; Mike Kuhn, BGS; Donna Jerry, BISHCA; Nick Emlen, Vt. Council; Greg Miller, Retreat Healthcare; Bill McMains, VDH; Terry Rowe, VSH

Staff:

Beth Tanzman, Judy Rosenstreich, VDH/DMH; Wendy Beininger, AAG/DMH

Announcements

Michael Hartman gave a legislative update on mental health bills:

- Legislature has passed and the governor has signed H.137 creating a Department of Mental Health. July 1 is the effective date.
- Legislative language to revamp the Futures Advisory Committee is being considered. It would replace the present structure with another body of family members and consumers, predominantly.

Larry Lewack, on behalf of the Advisory Committee, has sent the Governor a letter urging that he act on pending nominations to the VSH Governing Body. He announced the NAMI-Vermont walk / statewide fundraiser on May 19th to which all are invited.

Paul Dupre announced that Second Spring is open. They expect to have 3-4 residents by the end of the week.

Retreat Healthcare Proposal

Robert Simpson and Greg Miller presented the Retreat's proposal to partner with the State for a 16-bed specialized inpatient program and a 12-bed sub-acute rehabilitation residential program to provide some of the inpatient capacity required to replace the Vermont State Hospital. Peter Albert, an Advisory Committee member with a nearly 30-year tenure at the Retreat, also took part in the presentation.

Rob introduced himself to the Advisory Committee, sharing his background and commitment to working together. In his new role as CEO of Retreat Healthcare, Rob described the Retreat's status as Vermont's designated hospital for children and adolescents with mental health, addictions and co-occurring service needs. Greg discussed the Retreat's proposed clinical model that could meet part of the system goals of Futures. Peter focused on the Retreat's plans to develop outcome measures concerning utilization, readmissions, cost, quality, and consumer and provider satisfaction. The Retreat's PowerPoint presentation will be posted on the DMH Web site.

Discussion

Sandy recalled the attempt a few years ago to transfer up to 15 VSH patients to the Retreat. As this plan was not successful, how have circumstances changed such that a new initiative would fare better? Greg offered his thoughts although the 16-bed proposal that Sandy referred to happened prior to his tenure at the Retreat. He understood, however, that the need came up suddenly without the necessary time and resources to plan. It would have taken the right space, staff, program, and focus to succeed. Greg stated that, in contrast to that earlier arrangement, the current proposal is a product of thoughtful planning. The issue is to try to create programming that will move people to where they want to be. It includes the people who may get stuck in a hospital yet have needs that the community may not be able to fill. Rob emphasized the need for the Retreat to integrate with the community.

Xenia asked what role HCRS, the local mental health agency, might have in conjunction with the Retreat's plan. She expressed concern that the Retreat appears hospital based and that it may not be ready to work with the community system. Greg shared his view as a doctor, that he is not the source of recovery, that the interplay between hospital and community treatment involves tension, and that the goal is to promote recovery and help individuals achieve a recovered life.

Paul offered his perspective of a care plan that would be most conducive to recovery--- not a hospital but multiple programs around the state where the local home health agency would come to you, the resident. People get better out of the hospital; they are always *patients* in a hospital setting, which is a stigma in itself. Anything that can be provided in the community should be provided in the community, added Paul.

Rob shared his experience in Massachusetts where he turned over the emergency room of the hospital he administered to the community to run it.

PUBLIC COMMENT

Nick asked if the Retreat had in mind to admit patients from VSH only. Greg clarified that the Retreat's role would be part of the care management system in the Futures plan. For the residential part of the program, the Retreat has a house next to the farm on its property. They also own several houses in the community, which are children's residences. The Old Retreat Farm Road sits back from the farm with a view of the meadows.

Peter wanted to continue the dialogue begun today by talking, listening, and sharing ideas. He supported Xenia's comments about the importance of language and how to bring the goals around recovery to fruition.

Michael suggested that we come to the next meeting (June 4th) ready to talk about the retreat's proposal after everyone has had a chance to read it.

Act 114 Law and Procedures

A presentation and discussion of the Act 114 law and its implementation took place to help everyone gain a more solid grasp of the law's application. Wendy Beininger and Jack McCullough presented.

Wendy began by describing how Act 114 works, what is in law and regulation. Starting with a petition to the court, the law provides a mechanism for the State to treat someone with involuntary medication in a designated hospital. While the law allows this to be any designated hospital, VSH is the only hospital that provides medication under Act 114.

Other Act 114 provisions that the State has not implemented are:

- A provision of Act 114 that would apply to people on an ONH.
- An Act 114 petition for a person who is incarcerated.

In presenting a petition to the court, the State must provide clear and convincing evidence of the need for involuntary medication. The patient is entitled to an attorney and an independent psychiatric examination. If the court finds that the person is competent, then it is the person's decision whether to take prescribed medication. If the court finds that the person is not competent, then the case goes to the next stage.

Act 114 regulations offer a number of protections, including:

- Oral medication must always be ordered first.
- Restraints are not to be used unless necessary.
- Patient may have a person of the same gender if medication is by injection.
- A doctor must analyze, every 30 days, if the medication is still needed.

Jack had no disagreement about the law and procedures. He pointed out several issues:

Competency is defined in statute as...if the person is able to make a decision. He offered that VSH views competency as...if the person is willing to accept medication, s/he is competent. If you are not willing to accept medication and VSH thinks you need it, you are not competent. Jack cited the Vermont Supreme Court decision (2006) in which the court ruled that refusal to accept medication is not determinative of incompetence. It is necessary to demonstrate that the person does not understand, does not have the ability to decide whether to take medication.

Jack also discussed off-label use of medications. Once the FDA (U.S. Food and Drug Administration) approves a drug, any doctor can prescribe it for any condition. If a patient agrees to voluntarily take medication, the doctor can decide that a new medication is appropriate for one patient but not for another. In the administration of involuntary medication, there are different considerations.

Jack commented on Advanced Directives from the vantage points of (a) impact on the family, (b) religious preferences, and (c) guardianship.

The court has required the State to indicate that they at least have made an effort to find an Advanced Directive.

Jack cited the federal Religious Land Use and Institutionalized Persons Act. Under this law, an institutionalized person cannot be subjected to any treatment that interferes with religious practices. We do have people (in Vermont) asserting that taking psychotropic medications would interfere with their religious beliefs.

Regarding guardianship, if a patient is at VSH involuntarily and under a guardianship, who is going to make the decision about medication? How this is going to be resolved is still a question, according to Jack. Will it be Family Court under Act 114 or Probate Court under guardianship? Sandy shared her experience that it often is difficult to find guardians. She questioned whether allowing a guardian to make decisions about all medical care except psychiatry could have the unintended effect of attaching stigma.

Also discussed was the annual report on the implementation of Act 114, required of the State and issued by an independent consultant. The report indicates that the VSH staff feel that the process of obtaining a court order takes too long---84 days on average. The median time from filing the application for involuntary medication to trial is 11 days. In 2006, there were 36 cases, 18 of which were in October, November or December; most were filed and granted within these time frames. The preponderance of the cases toward the end of the year was a concern if the numbers were indicative of a trend.

Wendy addressed how Act 114 relates to adolescents. The law treats children the same as adults. A child would have to meet the criteria for admission to a hospital. The State designates hospitals by regulation; the Retreat could be designated.

In discussion about alternative treatments (in lieu of medication), Ed confirmed that there is much interest among some stakeholders who would like to see this explored. Promising things are occurring in other states, however, Vermont has not made strides in this regard.

Xenia suggested that patients who receive involuntary medications should be made aware of their right to a support person present.

There were no public comments on the Act 114 discussion.

In-patient Options / Cost Modeling

Beth addressed the need to analyze inpatient options in addition to the recommendation of the Advisory Committee given that a comparative analysis of several viable options would allow for a broader vetting process and assessment by stakeholders. For each of these options, the DMH will do an architectural, accounting, and program analysis. Beth distributed a draft in-patient option analysis list, noting that some options are not included such as “do nothing.” She invited feedback from the Advisory Committee. An open and credible examination of these options will enable us to settle on an option, move forward, and prepare our application for a CON.

Beth outlined a general timetable for this work, targeting late summer or fall to complete the option analysis. This will allow the Administration, legislators, and stakeholders time for review before the fall when a decision will be made.

Rob Simpson asked how the options presented consider specialized care. Beth explained that all of them are specialized, however, intensive care must be part of a tertiary care facility, Fletcher Allen being the only one in Vermont.

Jeff asked about the incarcerated population. Beth discussed the policy perspective that legal status should not be a proxy for clinical access. Cardiac care is but one example of a medical need that could affect anyone in our population, including people incarcerated. Access to care must be provided regardless.

The meeting adjourned at 4:30 p.m.

SUBMITTED BY: Judy Rosenstreich
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